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LEHIGH VALLEY MEDICAL MAGAZINE.

Vol. XII.

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No. 1.

ORIGINAL ARTICLES.

INJURIES TO JOINTS.¹

By C. H. OTT, M.D., OF SAYRE, PA.

Railroad surgery is a distinct branch of surgical science and the railroad surgeon of the present is called upon to solve problems which are rarely brought to the attention of the general practitioner.

In no branch of surgery is there greater demand for an accurate knowledge of the anatomy of the human body and the discerning ability to save the life or an injured limb of the patient.

The accidents met with are peculiar and their magnitude oftentimes appalling. The injuries are of such an extensive nature and loss of blood so great, that it requires the finest judgment and largest experience to decide what is best for the patient. Conservatism can no where be more strikingly shown than in this branch of surgery. Particularly in injuries of joints is there opportunity for the display of the highest surgical skill.

Within the memory of the youngest member present, an injury to a joint, especially those of the ankle, knee, shoulder, and elbow, was considered most unfortunate and dangerous. Even an incised, punctured, or lacerated wound, was fraught with the direst results. How much greater was the dread of those severe crushing injuries with which we still meet!

The more I contemplate the results of the surgery of the present day and recall the teaching of twenty years ago, the more I appreciate the fact that Lister is one of the greatest benefactors of the human race. To his indefatigable research within season, and analytical mind, is due the possibility of

¹ The address of the retiring president of the Association of Lehigh Valley Railroad Surgeons, read before the annual meeting, New York City, October 5, 1900.

present-day surgery. His is one of those rare, original minds of which few appear in a century.

How well I remember the slighting, half contemptuous remarks of some of my surgical teachers. Men, too, who possessed great skill and judgment. They failed to grasp the underlying principle, and magnified the inconveniences of the spray, and the possibilities of carbolic or bichlorid poisoning. These same men came to what were then the important operations, in street attire and only washed their hands after the operation. No wonder laudable pus was considered necessary for healing and, if nature or a kind Providence occasionally seemed to be lacking in its production, attempts were earnestly and generally successfully made to bring it about. It seems incredible that, notwithstanding Pasteur's researches, it should have remained for one man to work out the problem.

It would seem as a result of Lister's teaching, and of those who have so ably elaborated it, that the limit of possible surgical success has been reached. We no longer regard injuries of joints with more concern or dread than a proportionally severe injury anywhere else on the body. The great problem is not so much the mere saving of the limb, but the possibility of the joint's usefulness as well. All things being equal, asepsis will accomplish almost anything. There is no longer that apparent imperative necessity to amputate a limb. If a limb or joint is properly cleansed, there is often less danger in waiting to see what nature will do than in resorting to immediate amputation. This is scientific, conservative surgery. I invite your consideration to the following cases :

On August 31, 1897, Lamont Farr, aged 15, in jumping from a rapidly moving train, came violently in contact with a fence resulting in an injury to his right arm. He was brought to the hospital as soon as possible where, on admission, he was etherized and the following condition noted : Found the biceps and brachialis anticus completely torn loose from their attachments to the radius and ulna respectively, and the superficial flexors torn across and retracted downwards. The coronoid process was broken off, allowing the triceps to draw the forearm backwards. The external condyle, including the articulation for the head of

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the radius was broken off and comminuted. Extensive laceration of the skin about the joint allowed the above condition to be thoroughly examined.

The parts were scrubbed with soap and water, then with 1-500 bichlorid solution and sterile water and the usual dry dressing applied. The arm was placed on an angular splint. The patient reacted nicely. His highest temperature was on the morning of September 2d, when it reached $101\frac{1}{4}$; on the morning of the third it was $99\frac{1}{4}$ from which time on it was practically normal. September 3d, found the wound doing as well as could be expected. Arm badly swollen and contused from wrist to elbow. Reapplied splint with forearm in semi-prone position. The wound was dressed at intervals of four or five days on account of serous oozing. There was no pus, and on September 18th, I noted: Dressed arm this A.M.; looking very well. all sloughs have separated; made passive motion, pronation, supination, flexion and extension. September 23d, note: Dressed, made thorough passive motion.

This treatment was continued every four or five days as I was very desirous of securing a movable joint. We also employed Faradism to restore the tonicity of the muscles. On October 22d, I find recorded: Patient etherized this A.M., and made passive motion of right arm; forearm can be perfectly pronated and supinated; it can be extended to almost complete extension and can be flexed to slightly beyond right angle; the patient was discharged the next day with instructions as to what to do.

Some weeks ago, I wrote the patient in reference to the usefulness of his arm, and was informed that he had perfect pronation and supination, but no flexion or extension.

The cuts I show illustrate the condition at present. I believe had the patient had the courage to have persisted in the treatment, he would eventually have had an excellent joint.

The next case is an extremely interesting one on account of the multiplicity of the injuries received.

Willie Owens, aged 10, was admitted to the hospital on August 8, 1899. Shortly before admission, while running alongside of a moving train, he tripped on a board and fell against the train and sustained the following injuries:

1. A compound, depressed fracture of the skull over the left parietal bone.

2. Right foot torn completely off at the ankle, and the skin and subcutaneous tissues down to the muscles stripped up nearly to the knee, and the muscles contused and lacerated.

3. Left elbow sustained a compound, comminuted fracture. The inner condyle of the humerus and the olecranon process of the ulna were crushed off from the shafts of the bones.

The forearm was attached to the arm merely by the nerves, vessels, and flexor muscles. The musculo-spiral nerve was exposed for three inches, more or less torn and stretched. The skin was torn up from the deep fascia of the lower portion of the arm, and upper portion of the forearm, for at least eight inches. The wound was thoroughly cleansed with soap and water, 1-500 bichlorid and sterile water.

In order to retain the ulna in apposition with the humerus, both bones were drilled and a silver wire introduced and fastened. The skin was brought together as well as possible, bichlorid gauze dressing (1-1000) applied, and the arm placed on a right-angle splint. The depressed pieces of the parietal bone were removed, gauze-drain introduced, and bichlorid dressing applied.

The right leg was amputated at the upper third, the skin flap being taken from such of the skin as seemed likely to be in good condition, the object being to save the joint if possible. During the operation, he received 24 ozs. of saline under the breasts. August 9th, noted: Patient rested well and this A.M. is looking bright and feeling pretty well; temperature at 6 A.M., 98.6; pulse, 104. The patient did very well from this date on, except, that some of the skin on the arm sloughed, as did also the outer flap of the leg amputation. On August 21st, the leg was reamputated two inches higher up, just saving the joint.

On September 12th, the sloughs of the arm having all come away and the wound having granulated properly, he was again etherized and the ulcer covered with Thiersch grafts taken from the thigh. The silver wire which held the ulna to the humerus was removed. The recovery of the patient from this time was uninterrupted and he was discharged from the hospital, September 30th.

After the wire was removed on September 12th, passive motion was instituted and at the time of discharge he had flexion and extension to about 40°.

I have regretted having used silver wire to hold the bones together or not having removed it sooner. Had I brought the ligaments and soft parts together with catgut, passive motion could have been instituted sooner, with, I believe, more flexion and extension resulting. His pronation and supination were perfect. The unfortunate feature about these cases is that after they pass from one's care, passive motion is no longer persisted in and the best results obtainable are not achieved.

On November 3, 1899, Daniel Georgia, an engineer, was injured by the explosion of a locomotive boiler by which two men were killed and he sustained the following :

1. A compound dislocation of the right knee joint.
2. A compound fracture of the frontal bone.
3. Severe contusion of the left thigh with crush of second and third toes of the left foot. The interesting feature about this case was the knee-joint dislocation. The outer condyle of the femur protruded through the skin its entire size. Before attempting its reduction, the protruding condyle and surrounding skin were scrubbed with soap and water and 1-1000 bichlorid. The skin wound was enlarged and the bone reduced. The joint was then cleansed of blood clots and irrigated with 1-1000 bichlorid and sterile water. The skin was brought together after a small gauze drain had been introduced. The highest temperature recorded was on November 4th, 5 P.M., when it was 101.4, and the following noted: Feeling very comfortable; dressed knee, looking very well; wound absolutely sterile; irrigated joint with 1-1000 bichlorid and sterile water.

On November 8th, dressed and removed gauze drain.

On November 23rd, began passive motion. This was continued every two or three days and the patient was discharged on November 27th. Six weeks from the time of receiving the injury, the patient was walking without crutch or cane and had perfect motion. This case interested me very much on account of the prompt restoration of the usefulness of the joint.

The most remarkable case is, I think, the following :

On April 19, 1900, Jesse Horton, aged 20, was admitted to the hospital with the following history: A few hours previously, while reaching over a rapidly revolving saw, he slipped, and the back of his elbow struck the saw. The injury received was severe and he lost considerable blood. He was etherized and the following conditions discovered. The right elbow presented a lacerated wound posteriorly which involved the joint. The olecranon process was reduced to fragments and the external condyle of the humerus cut off. The forearm was attached to the arm by the flexor muscles, artery and nerves. When the arm struck the saw and the olecranon was cut through, the forearm was evidently thrown away from the saw, which would account for the arm not being cut off.

The wound was thoroughly cleansed as usual and the fragments of the olecranon removed. The external condyle was drilled and fastened to the shaft with a heavy catgut; the ligaments and soft parts were brought in apposition with catgut, a drainage tube inserted, usual dressings applied, and the arm placed on a right-angle splint. At midnight, the patient's temperature registered 102° ; at 4 A.M., 99.4° . It never rose higher. The patient made an uneventful recovery, and on May 7th was discharged from the hospital with a perfectly movable joint. Four weeks from the day of receiving the injury, he returned to work.

The excellent results obtained in these cases, I believe to be due to the following procedure: These severely injured people on admission are etherized and the injured limb and wound scrubbed with soft soap and water. It is impossible to cleanse any wound without an anesthetic; torn and ragged tissue is trimmed off. The wound is then most thoroughly scrubbed with a solution of bichlorid of mercury 1-500 or 1-1000, sterile water, or normal salt solution. Treated thus it is the rarest circumstance to have a wound suppurate. In fact, it so rarely happens, that there is no concern as to the result desired. I have never seen a wound thus treated and brought together with sutures fail to unite or the patient suffer from the absorption of mercury. As an antiseptic, bichlorid of mercury has given me better results than carbolic acid, formaldehyde, or any other.

The moral to be drawn from these cases is simply this: As

perfect attention to antiseptic and particularly aseptic surgery as possible.

I desire very sincerely to thank you for the honor bestowed upon me at our last meeting by electing me president of the Association.

REPORT OF A CASE OF RUPTURED KIDNEY—OPERATION—RECOVERY.¹

BY G. R. TROWBRIDGE, M.D., of Buffalo, N. Y.

Michael S. Pole, aged 42, was struck by a coal car coming rapidly down a grade in the Lehigh Valley coal trestle near this city, and thrown violently against the wall of the tunnel which is cut through solid limestone. Whether the car struck him in the back or whether he was thrown striking his back against the side of the tunnel I was unable to ascertain, nor was he able to tell himself. He was brought to Buffalo a distance of five miles on a locomotive and taken to the Fitch Hospital. Immediately on his arrival at the hospital he expressed a desire to urinate, and passed a urinal full of bright arterial blood mixed, I presume, with considerable urine. This was before I reached the hospital. After my arrival he passed two more urinals of blood, the vessel holding a little over one pint. He complained of soreness of the back on the right side, and a feeling of fulness, which latter could be distinguished by palpation. I made my diagnosis of severe injury to right kidney, as the hemorrhage, pain and fulness, weak pulse and pallor of the surface all pointed to this.

As it was my first experience in a case of this kind I called in Dr. E. J. Meyer to confirm the diagnosis which he did. On account of the alarming hemorrhage, operation was decided upon. Injections of strychnin and normal salt solution were given and the patient was hurriedly prepared for operation. A curved incision was made from the border of the ribs to the crest of the ilium. The blood poured out in excessive quantities, and for a few seconds the result looked extremely doubtful, as the pulse

¹ Read before the meeting of the Lehigh Valley Railroad Surgeons, New York, October 5, 1900.

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